DRVD
CONFIDENTIAL REPORT

AN INVESTIGATION INTO AN APPARENT SUICIDE

27 year-old, male former resident of Southern Virginia Mental Health Institute, died from an apparent suicide.

DRVD CASE # 98-0007M
Department for Rights of Virginians with Disabilities
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I. INTRODUCTION:

This report is a summary of the findings from an investigation conducted on behalf of the Department for Rights of Virginians with Disabilities (DRVD) into the death of EW, a twenty-seven year-old black male who was a former resident at Southern Virginia Mental Health Institute (SVMHI) in Danville, Virginia. EW apparently hung himself while incarcerated at the City of Lynchburg, Virginia jail at approximately 10:43 a.m. on October 16, 1997.

On September 30, 1997, EW was admitted pursuant to Court order to SVMHI for a forensic evaluation to determine EW's mental status at the time of the criminal offense and competency to stand trial for various criminal offenses. EW was discharged by SVMHI on October 15, 1997, into the custody of the Lynchburg Sheriff's Office and immediately transported to the Lynchburg City Jail.

The Department for Rights of Virginians with Disabilities authorized this investigation of an alleged incident of abuse and/or neglect of an individual with mental illness pursuant to the Protection and Advocacy for Mentally Ill Individuals Act of 1986.

This investigation included the following:

1. Review of EW's medical records at SVMHI;
2. Review of SVMHI's report of their internal investigation;
3. Interview with EW's treatment team and other staff members at SVMHI including, but not limited to, EW's physician team leader, primary therapist,

nursing staff, SVMHI clinical director, SVMHI risk manager, SVMHI director, and EW's forensic evaluators;
4. Interview with members of the City of Lynchburg Sheriff's Office;
5. Review of reports and notes from the City of Lynchburg Sheriff's Office;
6. Review of investigation report and interview transcripts from the City of Lynchburg Police Department's investigation into the death of EW;
7. Interview with members of EW's immediate family;
8. Interview with various community mental health workers in Lynchburg who had contact with EW; and
9. Review of medical examiner's report and autopsy of EW.

II. BACKGROUND

EW, a twenty-seven year-old black male, had been admitted to SVMHI on two prior occasions in October 1996 and October 1993. He also had previous admissions to the David C. Wilson Hospital in Charlottesville, Virginia and Virginia Baptist Hospital in Lynchburg, Virginia. According to EW's initial evaluation during his most recent admission to SVMHI, he first experienced psychiatric problems at age twenty-one. He has been diagnosed with Psychotic Disorder, Not Otherwise Specified and Personality Disorder. EW was consistently non-compliant with his medications and treatment. EW had been followed by the Lynchburg Community Services Board.

III. CIRCUMSTANCES SURROUNDING THE DEATH OF EW

A. Care Provided to EW at SVMHI and Sequence of Events

In the latter part September 1997, EW was incarcerated in the City of Lynchburg Jail awaiting trial on various criminal charges, including impersonating a police officer, simple assault, and brandishing a firearm. While incarcerated in the Lynchburg Jail, EW engaged in "bizarre behavior" including screaming, yelling, singing, howling, expressing paranoid thoughts, throwing his urine, and smearing his feces on himself, his food, and his cell. In response to this behavior, the Sheriff's Office contacted the City of Lynchburg Community Services Board (CSB) and requested a mental health consultation and examination of EW.

Pursuant to the contract between the CSB and Lynchburg General Hospital (LGH), a LGH licensed clinical social worker (LCSW) conducted a preliminary mental evaluation of EW on September 30, 1997. As a result of this evaluation, the City of Lynchburg General District Court ordered EW hospitalized for psychiatric treatment at SVMHI pursuant to Code of

Virginia, Section 18.2-174. The court also issued a temporary order of detention for treatment.

The LCSW wrote the following note in the Consultation Form, a copy of which was provided to SVMHI upon EW's admission:

> BEWARE OF/ADDENDUM -- Inmate has violent history. Is assaultive, disrespectful, and can be dangerous. He should not be trusted at this time. Sugg. security should be high. 2) Clothing should be minimal/as inmate gestures suicide with tee-shirts/sheets, etc. 3) Inmate history is that he grabs staff, throws food/water/urine. 4) Inmate says yes and means no. --- Beware.

EW was transported to SVMHI by the Lynchburg Sheriff's Office on September 30, 1997.

SVMHI utilizes a "team treatment" approach to patient care. Pursuant to this approach, upon admission to SVMHI, each patient is assigned a treatment team which is primarily responsible for the patient's treatment. EW's treatment team appears to have consisted of a primary therapist, physician team leader, nurse, two social workers, and a therapist. There is, however, no record in EW's file of the team members.

On September 30, 1997, an Admission Physical Evaluation was conducted by EW's physician team leader. This Evaluation included an initial treatment plan which called for EW to "begin inpatient treatment program including individual counseling, group counseling, activity therapy, and mental health education." EW was placed in seclusion on October 1, 1997, for "severely agit. behavior" and "disrobing, masturbating and for trying to get out of seclusion when staff goes in and threatening to hit staff." The nursing notes from October 1, 1997, state that EW was a "danger to self." He was again placed in seclusion on October 2, 1997, for "recent agitated behavior and need for rest and decreased stimuli" and "physically aggressive behavior." On October 2 and 3, 1997, he was placed on "special checks of 15 minutes" for "risk of harm to others and self." Special checks means that a staff member physically checks on the patient at the allotted intervals. On October 4, 1997, EW was placed on special checks for "risk of harm to self and others" and later placed in seclusion due to agitation. From October 5 through 8, 1997, EW was periodically placed on special checks of fifteen minutes due to risk of harm to self.

The SVMHI records reflect that on October 9, 1997, a "Comprehensive Evaluation and Treatment Planning Conference" was held by and between EW's physician team leader, primary therapist, and the nurse on EW's treatment team. This meeting is documented by a three-page document entitled Interdisciplinary Note. Under the "nursing" section of this note, the nurse wrote that EW is "awaiting for forensic eval. to return to jail." On October 10, 1997, EW's physician team leader wrote in the physician progress notes that "forensic eval to be done on 10/14 -- then return to jail."

On October 11, 1997, at 1:05 a.m., EW was placed on special checks of fifteen minutes "due to pt. voicing suicidal threats." According to the nursing notes, EW stated that "if I have to go back to jail I would just rather kill myself." At 1:10 a.m., EW was placed on constant observation "due to pt. exhibiting suicidal gestures (pt. wrapped sheet around door and then around neck)." On October 11, 1997, at 5:15 p.m., EW was placed on special checks of fifteen minutes "due to previous suicide attempt." Special checks were continued into October 12, 1997, due to his previous suicide attempt. At 10:05 a.m. on October 12, 1997, EW's special checks were discontinued "due to no longer being suicidal." On October 12, 1997, EW's physician team leader wrote in the physician progress notes: "Closely observe/ forensic eval in two days -- return to jail. Now again [with] suicidal ideation."

The forensic evaluation was completed at 1:30 p.m. on October 14, 1997. The forensic evaluators concluded that EW was sane and competent to stand trial. The SVMHI records reflect that a Discharge Staffing Conference was held on October 14, 1997, however, the only participants in this conference were the primary therapist and the physician team leader. The other members of EW's treatment team were not included in this conference. The primary therapist contacted the Lynchburg Sheriff on October 14, 1997, following this conference and made arrangements for EW to be transported to Lynchburg on October 15, 1997.

A Discharge Summary was dictated by EW's physician team leader on October 15, 1997. This Summary states that "[t]owards the end of his hospitalization, when patient was doing much better, his Haldol was discontinued because the patient refused to take it. He was strongly encouraged to continue his medication, but since he was doing well at the time, it is felt that it could not be given against his will." This Summary also states that EW "is to follow up with Lynchburg Counseling Center after he is released from jail, possibly to be seen in jail by their mental health worker." A Discharge Plan and Referral Summary form was also completed by the physician team leader on October 15, 1997.

On October 15, 1997, prior to his discharge, EW made three telephone calls to a lieutenant at the Lynchburg City Jail. EW was incoherent during these telephone calls and seemed to the lieutenant to be engaging in some of the same "bizarre" behavior that he exhibited prior to his admission to SVMHI. After the third telephone call, the Sheriff's Office contacted SVMHI to advise of the telephone calls and their concerns. A director at SVMHI, who had not treated EW during his admission at SVMHI, told the Sheriff's Office that EW "was a good actor." Approximately one hour later, the Sheriff's Department received a telephone call from EW's primary therapist who advised that EW no longer had any immediate mental health problems. The primary therapist further advised the Sheriff's Office that the Sheriff could send EW back to SVMHI if they experienced further problems with EW.

EW was transported from SVMHI to the Lynchburg City Jail by the Lynchburg Sheriff's Office on October 15, 1997. EW arrived in Lynchburg at approximately 4:35 p.m. Upon his return to the Lynchburg City Jail, EW recommenced his "bizarre" behavior, including smearing feces on himself and his cell. On the morning of October 16, 1997, the Sheriff's Office contacted the Lynchburg CSB to request an additional mental health consultation and examination of EW. Because EW was expected in court on the morning of October 16, 1997, a deputy allowed EW to shower so that he could clean himself for court. The deputy gave EW a sheet to dry himself because no towels were available. The deputy then left EW alone for several minutes. When the deputy returned, he found EW with the sheet around his neck.

The same LCSW who conducted the initial evaluation arrived at the jail at approximately 9:00 a.m. while EW was in the shower. The LCSW was waiting for EW to finish his shower when he was notified by Sheriff's deputies of EW's apparent suicide. The LCSW did not see EW alive on October 16, 1997.

The Report of Investigation by Medical Examiner identified EW's cause of death as "asphyxia due to hanging" and the manner of death as suicide. The Report of Autopsy from the Office of the Chief Medical Examiner identified the cause of death as "hanging by neck."

B. Interviews with SVMHI Staff

When asked whether treatment and discharge protocol differed between patients admitted for a forensic evaluation and patients admitted for clinical treatment, EW's physician team leader stated that forensic patients are

discharged following the completion of the forensic evaluation and patients admitted for clinical treatment are discharged when they are clinically ready to leave. The physician team leader also explained that pursuant to the SVMHI discharge process, the decision to discharge a patient is a team decision, but that the doctor writes the dismissal order.

EW's primary therapist stated that he only learned of EW's suicidal gestures on the day of EW's discharge, October 15, 1997. The primary therapist also stated that under SVMHI policy, the team makes the decision to discharge the patient and that the doctor writes the discharge order.

The nurse member of EW's treatment team had minimal direct contact with EW; she supervised the nurses assigned to treat EW. The nurse advised that in most instances, the treatment team would hold a meeting to specifically discuss the decision to discharge a patient. She advised that the decision to discharge EW following his forensic evaluation was made on October 9, 1997, by the nurse, primary therapist, and physician team leader. She stated that it was unusual that a team discharge meeting was not held in this case. She had worked on Friday, October 10, 1997, but did not return to the hospital until October 15, 1997, the date of EW's discharge. She advised that she was not aware of EW's suicidal gestures until after his death and that she "would have questioned whether EW should have been discharged" had she known of the suicidal gestures.

The SVMHI risk manager explained that the only difference in protocol between a forensic patient and a clinical patient is that a forensic patient obviously has a discharge placement (i.e., jail). The risk manager further explained that a discharge staffing conference is only required when there are questions regarding the appropriateness and availability of a post-discharge placement.

The director of SVMHI stated that EW was admitted to SVMHI for a forensic evaluation, not for treatment. She advised that when a patient is admitted solely for a forensic evaluation, the SVMHI staff does not need to prepare a formal discharge document.

The clinical director of SVMHI was responsible for overseeing the drafting of the SVMHI Clinical Policy and Procedure Manual. The clinical director assisted in performing the forensic evaluation of EW, but did not otherwise treat EW. When asked to explain the discharge policy, he stated that the discharge staffing conference is to be held by the treatment team to discuss discharge plans and the decision to discharge the patient. When asked whether the policies differed for forensic versus non-forensic patients, he

replied that such a conference is not necessary if the patient was admitted from jail and is returning to jail. In such cases, the decision to discharge a forensic patient, according to the clinical director, is made by the primary doctor. He then added that the treatment team would not return any patient to jail if the patient was not stable. When asked to explain the obvious inconsistencies with his statements (i.e., treatment team would not return a forensic patient to jail, however, the doctor alone, not the treatment team, makes the decision to release the patient), he replied that the SVMHI staff determines the appropriate procedure on a case-by-case basis.

C. Investigations

The City of Lynchburg Police Department investigated EW's death. This investigation found no basis of criminal activity in the death of EW. SVMHI also conducted an investigation. The authors of the report of the SVMHI investigation issued no "recommendations for other corrective and preventive actions." The SVMHI investigation also concluded that "[i]t is questionable whether [EW's] suicide was actually intended or a gesture gone wrong."

IV. FINDINGS AND CONCLUSIONS

This investigation revealed that (i) SVMHI is lacking a clearly defined policy regarding discharge procedure for patients, and more particularly patients admitted for forensic evaluations, and (ii) to the extent that a policy, albeit poorly defined, did exist regarding discharge procedures, the policy was not followed in this case.

The primary finding of this investigation, as revealed by the interviews with the SVMHI staff, is that the hospital lacks a clearly defined discharge policy. The "Discharge Process" is located at section VIII of the SVMHI Clinical Policy and Procedure Manual ("Policy Manual"). The Policy Manual requires that a "Discharge Staffing Conference will be held and plans for discharge will be documented." The Policy Manual fails, however, to provide any guidance on the following questions:

1. Who is required to attend the Discharge Staffing Conference;
2. Is the discharge process the same for all patients;
3. What are the goals, objectives and protocol for the Discharge Staffing Conference;
4. Who has the authority/responsibility to convene a Discharge Staffing Conference;
5. Who is in charge of conducting the Discharge Staffing Conference;

6. What is the protocol if there is disagreement regarding the decision to discharge a patient during a Discharge Staffing Conference;
7. Who has the authority to make the decision to discharge a patient;
8. If an individual has authority to discharge a patient, must this individual consult with anyone else prior to discharging a patient; and
9. What happens if the patient's status changes between the Discharge Staffing Conference and the time the patient is scheduled to be discharged.

Additionally, it was clear from the interviews with the SVMHI staff that some individuals believed that a different, less formal, discharge policy applied to patients admitted for forensic evaluation, as opposed to patients admitted for clinical treatment. There is, however, no such distinction in the Policy Manual.

The Policy Manual also requires that a "preprinted 'Discharge Staffing Note' will be completed at this time." The Policy Manual, however, does not advise as to who is responsible for completing the discharge staffing note; who is required to sign the discharge staffing note; and the required content for the discharge staffing note.

Despite the ambiguity of the SVMHI discharge process, as detailed above, EW's physician team leader and primary therapist failed to comply with the Policy Manual discharge process. Both the primary therapist and the physician team leader advised that the decision to discharge a patient should be made by the treatment team. Neither, however, consulted with EW's treatment team members prior to authorizing EW's discharge. The nurse member of the treatment team was consulted by the primary therapist and the physician team leader on October 9, 1997, six days prior to EW's discharge. While she agreed with the decision to discharge EW at that time, she was never re-consulted following EW's suicidal gestures on October 11, 1997. The nurse advised that had she been made aware of EW's suicidal gestures and had she been consulted prior to EW's discharge, she would have questioned the decision to discharge EW.

Furthermore, while the Discharge Staffing Note was completed and signed by the primary therapist and the physician team leader, the preprinted Note form also contains a signature line for the social worker, thus indicating that EW's social worker was required to execute the Note as well. The signature line for EW's social worker on the preprinted Discharge Staffing Note was blank.

Additionally, the primary therapist's participation in the decision to discharge EW was not meaningful. The Discharge Process in the Policy Manual suggests the following criteria, **inter alia**, for determining patient readiness for discharge: patient is no longer a danger to self or others, and patient has received maximum benefit from inpatient hospitalization and is able to continue in therapy as an

outpatient. The primary therapist admitted that he was unaware that EW had engaged in suicidal gestures within days of the decision to discharge EW. Thus, the primary therapist could not have addressed in a meaningful manner whether EW was no longer a danger to himself in that the primary therapist was unaware of EW's most recent suicidal gestures.

Finally, the justification offered by various SVMHI staff members for the failure to follow the Policy Manual in the instant case -- namely, the designation of EW as a "forensic" patient, not a clinical treatment patient -- is misplaced and unsupported by the medical records or the Policy Manual. As stated above, the Policy Manual does not permit a less stringent discharge process for a patient admitted for forensic evaluation, as opposed to a patient admitted for clinical treatment. Additionally, the SVMHI records clearly reflect that EW's treatment team believed that EW was in need of clinical treatment. EW's initial treatment plan, drafted on September 30, 1997, by EW's physician team leader, provided for EW to begin inpatient treatment program including individual counseling, group counseling, activity therapy and mental health evaluation. Thus, even if the discharge process differs for forensic patients, EW's medical records reflect that EW received clinical treatment and thus should have been subjected to the discharge process provided to clinical patients.

V. RECOMMENDATIONS

The following recommendations are suggested based upon the above findings and conclusions:

1. The Discharge Process portion of the Policy Manual should be fully revised to address the issues raised in the preceding section. The manual should specify the precise procedure for determining whether a patient is ready to be discharged. It is suggested that the policy require that all individuals responsible for the decision to discharge a patient should be informed in a meaningful manner of the patient's history, progress and status during his or her hospitalization.

2. The Policy Manual should reflect whether the discharge process differs for patients admitted for forensic evaluation as opposed to clinical treatment. It is recommended that if such a distinction is made, the manual should set forth a distinct discharge process for forensic patients who receive clinical treatment, as in the case of EW.